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PROGRAM GOALS FOR CHILDREN WITH CEREBRAL PALSY*

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As I speak with you about goals in a program for handicapped children, particularly those for children with cerebral palsy, I do so as an administrator whose responsibility it is to coordinate effectively the services provided by varied disciplines: physicians, teachers, parents, nurses, social workers and citizens. Broadly speaking, I represent those who come in daily contact with the children and whose activities form the solid, basic matrix of California's Crippled Children Services program. I speak also as a physician, who is concerned not only with definitive treatment, evaluation of results and new methods but also as one who is growing up with the concept of rehabilitation in its broadest sense. I bring, in addition, my own personal convictions stemming from an ever increasing awareness of the worth of every child—each as an individual with his own dignity, his own right to happiness, and through these, his own particular value to society.

Although it might be helpful if I could approach each of these aspects separately, they are so related that simplification becomes impractical; for all are part of the whole complex approach to goals for children with cerebral palsy.

Goal for All Children

First of all, I believe that, simply stated, our goal for all children is that they have an opportunity to achieve

maturity. Perhaps the best definition of maturity is one Sigmund Freud gave. Asked for his definition, he gave it so readily it comes as a surprise even to the reader. He said that maturity is the *ability to love and to work*. I find it difficult to add anything to this definition, although one might meditate upon or discuss for long hours all of the ramifications and implications which surround it.

If this is the goal for all children—the ability to love and to work—we must include the handicapped child; although it may be necessary to establish for him certain specific and lesser goals as stepping stones to reach it. As adults, we must therefore consider some of the methods by which the handicapped child can be helped to master, step by step, those lesser goals which lead to the final goal of maturity.

In our present society, we tend to place great emphasis upon methods of organization when we consider educational or treatment programs. We like to have specific plans in which our duties, functions and activities are catalogued, assigned their special places, and are capable of being outlined and analyzed according to some method. This is a sound and orderly tendency; good organization is essential to effective action. But before we begin to think in terms of organization, I invite your attention to some concepts which, to me at least, are basic and fundamental to any program truly designed for children. They are:

First, that each child, with few exceptions, possesses a tremendous driv-

ing force—both for life and for growth. That although certain experiences may have diminished the strength of this force, like the proverbial “wet blanket,” it can be released if the obstacles can be removed; and once released, growth will begin again. This is the most precious element in life; it is indeed life itself. Therefore, our job as adults is to concentrate on those obstacles which stand in the way of the child's drive with deep faith that growth will of its own force proceed.

Second, that this growth is a step-by-step progression which takes place in an orderly manner. This is so in both the development of personality and in the development of physical or motor skills. A child does not walk before he can crawl; he does not talk before he has babbled (and I suspect, until he has completed satisfactorily the sucking stage); he cannot love unless he has learned to trust. The mastery of each new step is dependent upon his success in mastering the preceding phase. I suspect that the uneven development in children with cerebral palsy lies, to some extent, in the failure to master completely and satisfactorily the successive steps in the areas of personality, intellectual development and motor skills. Out of this situation arises confusion for the child and frustration for parents and staff. Often we have not sufficiently oriented our thinking to the natural progressions which exist for these children in their attempts to achieve and move ahead.

*Adaptation of presentations before the American Physical Therapy Association, Los Angeles, 1954, and Orthopaedic Hospital's First Annual Workshop in Speech Problems in Cerebral Palsy, Los Angeles, July, 1955.

Third, that each child, even a handicapped child and even a child with cerebral palsy, has assets as well as disabilities and that we must condition ourselves to think in terms of these assets. This approach requires an almost complete revolution of our present thinking. Our culture and our own technical training conditions us to intense concentration upon the disability, the defect, the disease, and upon their remedy. And in our emphasis upon the disability, somehow the child seems to be left alone to discover his assets and to make the most of them as best he can. This is an unfair burden. Fortunately, there is now some evidence of a change in this attitude.

A Positive Approach

An article appeared recently which described the emotional problems of a paraplegic as experienced by a psychiatrist who suffered a broken back in a household accident. Through the positive attitude of the physician who evaluated her after the acute episode, she was helped tremendously. He did a careful, thorough examination and then said, "You have brains and good arms. Let's go to work." He did not confuse and overwhelm her with the reality that she was a permanent paraplegic. Instead, he gave a positive and firm footing from which she could move forward. I have seen one or two reports recently on children in our program in which, although the basic disabilities were described, the emphasis in planning was on the assets. We must say continuously: "This is what we have. Let's go to work"; for however limited those assets may be, we at least have a positive approach which the child needs if he is to mobilize himself for living.

The wide acceptance of such concepts by each member of our staff must be our primary goal. These concepts form the foundation on which to build; they create an environment for the development of definitive treatment techniques and for the organization of treatment into an effective service program. I would hold that a basic philosophy embracing them is vital to all phases of a program and to all professional disciplines, from the administration to the staff in each school, hospital, public or private agency, clinic, rehabilitation center, and perhaps most impor-

tant of all, in the home and in places of employment.

Program Objectives and Problems

Having crystallized our philosophy, we should now consider some of the specifics of the Crippled Children Services program, some of its objectives and some of its problems.

Children with cerebral palsy present special difficulties in the organization of treatment services. The nature of the handicap, together with its effect on physical growth, on personality development and on the learning process requires treatment by more than one discipline. Medical treatment alone has not been very effective and, likewise, education alone has met with equal failure. It is, therefore, necessary to organize services so as to facilitate a joint approach at all times.

This idea of a joint approach is generally accepted as basic to the structure of a cerebral palsy program. The question to be resolved has been that of administrative jurisdiction. There is a strong inclination in some groups to centralize in a single administrative agency which encompasses all disciplines: that is, one in which therapists, public health nurses, nutritionists, social workers, vocational counsellors and sometimes physicians are responsible to the same administration. Usually this agency has been the school system since health agencies have never undertaken the educational phases of the program, whereas school departments have sometimes provided treatment services. In other places there has been the equally strong belief that the best results can be achieved through co-ordination of activities rather than such centralization. Such a plan utilizes the skills of each discipline, includes a variety of community resources and agencies, and depends for completeness upon broad participation and integration through interest in a unified approach.

Core Treatment

There are many controversial aspects in each approach. In California it was decided, when the cerebral palsy program was initiated in 1944, that two major agencies, health and education, should coordinate their skills to form a core treatment pro-

gram; and that all general or specialized community services would be drawn upon as needed.

This "core treatment program" is, of course, only a part of the total services which children with cerebral palsy require. Administratively, it represents an assignment of the basic services to the departments of health and education with welfare programs participating as a part of the Crippled Children Services basic structure. It is dependent upon the local administrative organization for its stability. Other existing community services, especially those provided by voluntary agencies with their vital interest in all handicapped persons, complete the total service program.

This organized treatment program has been predicated upon the following principles:

1. That children belong with their families and, therefore, services must be available in local communities where the children live.
2. That the segregation of handicapped children is detrimental to both handicapped children and to normal children; it denies to both necessary and reasonable experiences. Therefore, special units for education and therapy should be in close association with regular elementary schools and other activities of normal children, and all other planning should follow this integrated pattern.
3. That careful diagnosis and evaluation should precede the treatment plan, and that the treatment plan should begin early and follow immediately the establishment of the diagnosis whether the child is six weeks or six years old.
4. That an effective treatment program must infiltrate the daily activities of each child, at home, at play and at school; for as with normal children, skills are learned only through constant practice and repetition. Neither therapy nor education can take place in a vacuum isolated from the daily life of the child.

In California, services have been organized to support these fundamental concepts as far as possible. Following a survey in 1944 of the

cerebral palsy problem, a program was outlined which gave joint responsibility to the Departments of Health and Education at the state level. Along with a legislative mandate, funds were made available to these departments to assist in the establishment of cerebral palsy units in local schools. This legislation provided for changes in the Education Code as it applied to the age of admission to a class for handicapped children. The age of admission is now set at three years as compared with four years and nine months for admission of normal children to kindergarten and five years and nine months for their admission to elementary school. It also provided for financial assistance in three areas: 1. increased average daily attendance funds to school districts above what is provided by the State for the education of normal children; 2. matching funds for construction of school buildings; 3. more recently, assistance in financing costs of transportation to and from school.

The State Department of Public Health had long been responsible for a broad program of services to handicapped children in which diagnosis and treatment were already available. It was, therefore, necessary to finance only the intensive physical therapy and occupational therapy services so essential to the treatment of cerebral palsy. This meant both supervisory and staff therapists with an augmented program of medical supervision, surgical treatment and a more specialized approach to the provision of appliances than had been previously available.

Special Units in Schools

Gradually, special units for children at the elementary school level have been established in 50 locations throughout the State. As the plan has developed, the local schools, aided by state funds from the State Department of Education, have been responsible for the provision of adequate space and for the equipment of the complete unit. The local school district has also provided for teaching staff and matron services, and for transportation of the children to and from school. The health department has been responsible for the provision of staff for physical and occupational therapy, for medical supervision and

for financial assistance to families when braces and other definitive medical care is required.

Medical supervision is provided in these units by an orthopedist or pediatrician who is in the school at regular intervals. These scheduled visits take the form of clinic conferences, the frequency of which depends upon the need. New children are seen during these sessions and children under treatment are reviewed. In addition to regular examinations of the children by the physician, conferences are held with teachers and with parents. Attendance of the physician at the school permits an effective group evaluation of each child by those responsible for his treatment and education. It also has the advantage of providing a method of interchanging of problems in the respective fields. Such conferences include all the unit's staff and other representatives, such as members of the public health nursing staff of the health department and workers from the social agency when they have been involved in planning for the child or his family.

Geographically, the State is fairly well covered by local cerebral palsy units and medical treatment, combined with education, is being offered to approximately 2,700 children. Of the 50 units now in operation, 15 are staffed by one physical therapist; 6 are staffed by one occupational therapist; 11 are staffed by one physical therapist and one occupational therapist; 18 have two or more physical and occupational therapists. A total of 122 therapists are working in the program of which 69 are physical therapists and 53 are occupational therapists.

Diagnostic Centers

It was originally planned that each child should have a complete diagnosis and evaluation prior to the establishment of the treatment plan. The diagnostic process was to have been provided through diagnostic centers established in connection with medical centers. Unfortunately, the demand for services and treatment increased so rapidly that it became necessary to provide basic diagnostic procedures as a part of the cerebral palsy unit in the local schools, reserving the diagnostic centers for children with difficult problems and for

those living in rural areas where no other facilities were available.

There are currently four diagnostic centers: three in Southern California and one in the northern part of the State. All of these centers are attached to hospitals or medical schools and the medical staff of the centers are members of the hospital staff or medical school. They serve both in the diagnostic centers and in the two residential schools, which are available for short-term, intensive training for those children in need of such service.

In the diagnostic centers children may receive: (1) extensive diagnosis and evaluation (this includes pediatric, orthopedic and other special examinations needed, such as eye, hearing, neurology, psychometric tests, speech evaluation and social and educational diagnosis); (2) evaluation for admission to the residential schools; (3) treatment on an outpatient basis for children living in areas where no local cerebral palsy unit is available.

In the residential schools which have a capacity of about 40 children, selected children may receive a longer period of diagnostic observation, special education and intensive physical and occupational therapy. In the residence situation it is possible to integrate treatment more fully into the child's daily activities since the total environment may be geared to this objective. In addition, these schools make both research and teacher training possible. The diagnostic centers and the residential schools are under the jurisdiction of the State Department of Education.

To summarize, the core services of the cerebral palsy treatment program are the local day schools with their therapy units, clinic conferences and medical supervision; the diagnostic centers for more selective evaluation; and the residential facilities for short term, intensive treatment and for research and training. This is California's official program for this group of children, as it looks after 10 years of development.

With this pattern of services established, where indeed very little existed before, we are discovering that experience is dynamic. Having established a pattern, we are impelled to examine it carefully, retaining and extending those practices proven to

be effective and discarding or revising those which have not worked out well for the children.

Coordinated Evaluation

Most firmly we have come to realize that a coordinated evaluation of each child is a prerequisite of a sound treatment plan. This evaluation should include a determination of the stages in development which have been successfully mastered by the child—and, beyond this, an evaluation of the environment in which he lives. A sound program should include not only specific therapies but in addition a suitable environment at home and in the school; one in which each child can move progressively toward his own goals. This type of coordinated planning and evaluation demands broad organization and adequate resources which, as yet, we have by no means fully achieved.

Needs of Older Children

There are two areas in which specific revisions may be necessary. Because our work has been directed primarily to the child at the elementary level, we have not critically determined the particular needs of either the younger or older children. As we look at them, in terms of individual children, it seems highly improbable that the same basic pattern of services with minor changes in emphasis only can be expected to provide adequately for both preschool and teenage children. We must begin now to review their programs and develop services more particularly adapted to these age groups. It may be that our efforts for the preschool child should be directed more specifically to aiding him to master satisfactorily those first steps in growth process, which appear so simple for the normal child: sucking, eating and elimination, through which a sense of trust is developed. We realize that this may require more services to the parent than to the child, and perhaps an entirely different kind of professional staff. But we believe that early recognition and evaluation are extremely important and that we must find a way to reach the younger child and the infant with the same kind of carefully planned program that we want for the school age child. This is a difficult prospect. It will require in each of us a willingness to study and to experiment until

we know more about the type, amount and direction of treatment which can be organized effectively into a program for the preschool child.

To be considered also is the other end of the age range, the children from 15 to 21. We must determine what adjustments must be made for them. At this stage of development, the child is faced with three great problems. First, as a child he must pass physically and emotionally through the very trying period of adolescence; secondly, he must experience his adolescence to a large extent without physical activity which usually provides a reasonable outlet for emotional restlessness, so that his physical limitations now become more frustrating; finally, he must face the future as a mature person who wants to love and work. Where and how will he find satisfaction in these areas?

Here again, we have not shifted gears but have merely carried over the methods and techniques of the elementary schools. Somehow I have a suspicion that the program for the elementary school child falls short of meeting the needs of adolescents and that our bold attempts to squeeze them into it may be creating problems for both the children and the staff.

Certainly it is true that we have not provided a transitional experience from which this group may pass from childhood into young adulthood. We have given them little or no opportunity to test their assets in a protected work situation, or even to find out what their interests and abilities are and how they may be adapted to adult living. We have not helped each child to understand sufficiently his own needs and desires and how these must be converted and re-established on an adult level. I do not mean to say that we must accept as inevitable a frustrated maturity for the handicapped child. Basic to the help we must give must be our own full realization that every human being in becoming an adult must learn that frustration of some of the desires and dreams of childhood is part of life, and that satisfaction in maturity lies primarily in mastery and creativity within the framework of the individual's capacities. Bringing all this about would seem to call for study of the adolescent and his needs, finding new services and new staff to provide

services in an environment more appropriate to the emerging adult.

As we review our situation now, we see that in addition to the need for a program based on the dignity and value of each person, formulated with real understanding of the progression of growth; and implemented by a treatment program directed to strengthening the mastery of first steps first; a reconsideration of the essential pattern and direction of services for the very young child and for adolescent groups must be our next steps.

Attitude of Society

One final concern commands our attention. This relates to our responsibility for the attitude which society assumes toward the so-called "handicapped" individual. Since these attitudes are part of the environment in which the child lives and functions, they determine in large part his chances for success. All of our specialized treatment, our best programs for training will be lost, if finally the handicapped individual must live in a world of constant rejection.

We have witnessed some changes in attitude through the years. There was the dark age of shame during which handicapped children and adults were hidden, often literally, in the closet. Then came the age of sentiment and pity, which is no less destructive to the fibre of the human soul than the darkness. More recently, we hear stern talk about helping the handicapped to "face reality." What is this reality? Can we be certain that it is not a stereotype category, into which all that group known as the "handicapped" must be automatically and irrevocably placed?

The way in which these questions are answered determines the premise upon which attitudes are built. To form proper attitudes, society is badly in need of facts about the tasks and jobs of work individuals with handicaps can do. Encouragingly, a few agencies have been successfully blazing trails in their work with industry. Their continued success will depend on the adequacy of prevocational guidance, vocational training and proper placement in the labor force.

Acceptance by society generally has not been comparable. It is a slow process which must grow out of social acceptance of the handicapped

child by his own companions. I feel encouraged whenever I see the child with cerebral palsy intermingling in the school yard with other children. I am encouraged also when I hear discussion about integrated camps for children. But I am inclined to be critical of special settings for treatment and training, unless they provide ample opportunity for the handicapped to work and play with the so-called normal child.

I have faith that the day will come when all these children, having had their childhood together, will grow up and bring about a new environment; one in which we will have come to accept, to understand and to enjoy individual differences.

Frontiers for New Activity

Beyond what has just been discussed, there remain in my opinion, three major areas which have been almost completely untouched in the field of cerebral palsy. They are real frontiers for new activity:

1. The first of these is prevention. In the past few years, the advances in medical science have not been an un-mixed blessing. We are accepting responsibility for an increasing number of severely involved children, who are alive precisely because of the remarkable scientific advances made in the care of infection and disease. While we rejoice in our expanded knowledge, we must ask ourselves whether techniques of rehabilitation will keep pace. We are faced then, as professional people, with two equally difficult requirements: the provision of rehabilitation, education and treatment of the severely involved child, and the coincidental or concurrent development of ways of preventing these handicaps. As we come face to face with a difficult rehabilitation task we begin to raise the question: Are these conditions necessary? Can some be prevented? More research is being directed to the etiology of cerebral palsy and we hope the result will be improved methods of prevention. These are developments that must be encouraged, supported and watched. Success here will eliminate a great part of our rehabilitative task.

2. In the meantime, there is need to study the impact of a disability at birth on the development of personality. We have frequently said that

Agnes O'Leary, UCLA Professor, Heads SC Public Health Association

Miss Agnes O'Leary, Assistant Professor of Public Health Nursing, University of California at Los Angeles, was installed as 1956 president of the Southern California Public Health Association at the annual meeting held December 16th in Glendale. The all-day meeting was attended by more than 300 persons, and 180 attended the luncheon.

Miss O'Leary, who served as president-elect in 1955, succeeds Dr. L. S. Goerke, professor of preventive medicine and public health at U. C. L. A., in the presidency. The 1956 officers are as follows, with the hold-over members of the Executive Committee listed under the heading 1955-56, and the newly elected members for a two-year period listed under 1956-57:

Officers for 1956

- President**
Miss Agnes O'Leary, Assistant Professor of Public Health Nursing, University of California
- President-Elect**
Mr. A. Harry Bliss, Chairman, School of Public Health, U. C. L. A.
- First Vice President**
Everett Stone, M.D., Health Officer, Riverside County Health Department
- Second Vice President**
Mr. J. Albert Torribio, Acting Director, Division of Public Health Education, Los Angeles City Health Department
- Secretary-Treasurer**
Gerald A. Heidebreder, M.D., Chief, Venereal Disease Control, Los Angeles County Health Department
- Assistant Secretary-Treasurer**
Mr. Donald Suggs, Public Health Engineer, Los Angeles County Health Department
- Representative to Governing Council, A. P. H. A. and Immediate Past President**
L. S. Goerke, M.D., Professor of Preventive Medicine and Public Health
- Representative to Regional Board, Western Branch, A. P. H. A.**
Gerald A. Heidebreder, M.D.



AGNES O'LEARY

Executive Committee, 1955-56

- Ferne Hood, P.H.N., Coordinator of Health Education, Los Angeles County Schools
- Mary McQuillen, P.H.N., Nursing Educational Director, Los Angeles County Health Department
- Wilbur J. Menke, M.D., Health Officer, Pasadena City Health Department
- Byron Mork, M.D., Assistant Professor Epidemiology, U. C. L. A.
- Harold N. Mozar, M.D., Director School of Tropical Medicine, C. M. E.
- Edwin Watkins, Sanitarian, San Diego County Health Department

1956-57

- John Beeston, M.D., Associate Professor, School of Public Health, U. C. L. A.
- Harold Mazur, M.D., Medical Director, Cedars of Lebanon Hospital, Los Angeles
- Belle Dale Poole, M.D., Medical Officer, Maternity and Child Health, California State Health Department
- Myona Morrison, R.N., P.H.N., Director, Public Health Nursing, Kern County Health Department
- Harriett Randall, M.D., Assistant Medical Director, Health Services, Los Angeles City Schools
- S. Mark Doran, M.D., Psychiatrist, Pacific Palisades

the major problem in treatment is that of motivation of the child. The disturbance of the normal pattern of growth and personality development can have destructive consequences of major importance. The lack of satisfaction in early feeding; the lack of stimulus from verbal communication, the restriction of physical activity—these are some of the problems we face in the rehabilitative program. Once we can understand the manner of such disturbances in the development pattern, it would seem possible to develop adequate ways of avoiding them.

3. Finally, little if anything has been done to guide and train children at the elementary school level along even the most general vocational lines. There is no greater tragedy than the child who reaches the age of 21 years without fully understanding his restricted vocational opportunities, and who has had no training in a field in which he can function adequately and with satisfaction. The addition of a vocational counselor to the rehabilitation team might help to guide the therapist in more definitive functional training.

(Continued on page 120)

Hospital Advisory Board Holds Public Hearing on Regulations

The Hospital Advisory Board considered proposed changes and amendments to the Hospital Licensing Act and licensing requirements in a public hearing January 12th in the Berkeley headquarters of the State Department of Public Health.

At the request of representatives of the Structural Engineers Association of California and the Consulting Engineers Association of California, the board deferred final action on requirements for correction of structural deficiencies of substandard hospital buildings. The engineers said that they would need more time to study the proposed structural requirements and would present recommendations to the board in approximately six weeks.

This action was proposed following an opinion from the Attorney General's Office and the Hospital Advisory Board that the State Department of Public Health has a responsibility under the present Hospital Licensing Act and licensing requirements to be concerned with the structural stability and safety in existing hospital buildings.

In order to obtain information on the scope and complexity of the problem, the department is having a structural engineer make a preliminary survey of older multistory masonry buildings in various locations throughout the State. To date, this preliminary survey is about 60 percent complete. In this preliminary survey or in future surveys by the department where a building is considered to need further structural evaluation, the department will request that the owner or operator of the facility assume responsibility for obtaining a more detailed and complete structural safety report on the building by its own engineer, including recommendations for correction.

It is planned to present the proposed action before the State Board of Public Health for adoption at its June meeting.

Approved by the Hospital Advisory Board was an amendment which requires the licensing of one-bed nursing homes previously exempt from the requirement of a license. The change in the basic licensing law re-

JUST SO YOU'RE NOT CONFUSED

In this issue are reports of January meetings of the Department's Advisory Hospital Council and the Hospital Advisory Board. Both the council and the board are appointed by the Governor.

The Advisory Hospital Council was created by legislative action to advise the department in matters relating to the hospital and health center construction program. Members are both professional and non-professional. They assist in the development of criteria for determination of need for assistance in various parts of the State and recommend where federal and state funds shall be allocated for hospital and health center construction. Present members of the council are:

George J. Badenhause, Long Beach
Harold D. Chope, M.D., San Mateo
Forest J. Grunigen, D.O., Los Angeles
C. T. Lehmann, Los Angeles
V. C. Meedom, Crescent City
Mrs. I. H. Teilman, Selma
C. V. Thompson, M.D., Lodi
George U. Wood, Oakland
Malcolm H. Merrill, M.D., Berkeley,
Chairman

The Hospital Advisory Board is composed of hospital administrators who advise the department on legislative matters pertaining to hospitals. They assist in establishing minimum standards for licensing and operation of hospitals and clinics, and recommend the adoption of necessary regulations by the State Board of Public Health. Present members of the Hospital Advisory Board are:

A. A. Alta, Upland
David W. Lawrence, Long Beach
George B. Nelson, Glendale
V. W. Olney, Bakersfield
G. Otis Whitecotton, M.D., Oakland

quired corresponding changes in the definition of the terms "hospital" and "nursing, convalescent and rest home," as defined in Section 231 and 235 of the licensing requirements. (California Administrative Code, Title 17, Public Health.)

The meeting provided an opportunity to obtain more information on the problem of serious accidents involving anesthesia equipment in hos-

(Continued on page 119)

Advisory Hospital Council Considers 1956-57 State Plan

Proposed policies to be included in the 1956-57 State Plan for hospital and health center construction were considered at a public hearing of the State Advisory Hospital Council January 13th in the Berkeley headquarters of the State Department of Public Health. A subsequent policy meeting will be held in Los Angeles April 9th-10th to establish policies to be incorporated in the State Plan for the Fiscal Year 1956-57, which will govern the allocation of state and federal hospital and survey construction funds. Public hearings on the completed plan will be conducted by the department in Los Angeles and Berkeley in June, and allocations of the Fiscal Year 1956-57 will be made either July 26th-27th, or September 13th-14th, in Berkeley, the date depending upon congressional appropriation of federal matching funds.

Deferred until the April hearings was a proposal for revision of the basis for estimating area bed need. In areas which have more than one application, the number of projects which qualify for allocation will be limited to those which can be approved without increasing the hospital beds in the area above the average percentage of bed need met in all areas of the State.

Approved by the council was a recommendation that in areas where a hospital facility is condemned and patients evacuated, that replacement of condemned facilities will be limited to the minimum investment required to restore the condemned facility to a condition where it will be structurally safe for patient use. For purposes of applying this policy, a condemned facility is defined as one which the department determines must be evacuated in the interest of patient safety.

The council considered a proposal to limit allocations to counties for general hospital construction, except in special circumstances, to not more than 25 percent of the estimated general hospital bed need of the area. The council determination on this question was that county situations are so dissimilar that establishing a fixed ratio

(Continued on page 119)

Public Health Positions

San Diego County

Health Information Specialist: College graduates with experience in the use of mass media for public health information are eligible for a new position open with the San Diego Department of Public Health. Salary range, \$378-\$460. For details write San Diego County Civil Service, Room 402, Civic Center, San Diego.

State of California

Health Education Consultant: Examination date has been set tentatively for May 5th, with the final date for filing April 13th. Salary range, \$481-\$584. For further information write to Mrs. Marguerite Morgan, Personnel Officer, Room 713, State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

Hospital Advisory Board Holds Public Hearing on Regulations

(Continued from page 118)

pitals. Further study will be made and a report given to the board in about six weeks. Because of the time necessary to change over such equipment to safety systems, the Bureau of Hospitals is to work out a phased schedule with anesthesia equipment manufacturers and gas manufacturers for the changeover.

The board approved a regulation which provides that oxygen shall be administered to infants only on the written order of a physician, which shall include the concentration (volume percent) ordered by the physician. This was the outgrowth of a report of the Department's Advisory Committee on Retrolental Fibroplasia on the causal relationships between oxygen administration and retrolental fibroplasia, which evidence has implicated as an important cause of blindness in premature infants. (See *California's Health*, July 15, 1955, pp. 11-13.)

Approved were various sections of the Maternity Regulations, based upon recommendations from two regional conferences on maternity and newborn care in general hospitals. These amendments to the licensing requirements which relate to isolation of maternity patients, isolation of newborn infants and dressing rooms and lockers for personnel, are intended to provide for more flexible and economic operation of maternity departments in general hospitals.

Section on Mental Health Created By APHA at Annual Meeting

Approval for a mental health section was voted by the Governing Council of the American Public Health Association at its 83d annual meeting, November 14-18, at Kansas City, Missouri. Formation of the Mental Health Section, the 14th to be formed in the association and the first added since 1948, is recognition of the importance of the problem and the interest of the people serving in this field. Dr. John D. Porterfield, director, State Department of Mental Hygiene and Correction, Columbus, Ohio, was elected chairman of the section.

The Committee for a Mental Health Section expressed the objectives of the section as being:

1. To help develop interest and leadership on the part of all health professionals and their organizations in the public health aspects of mental disease.
2. To provide a forum for the exchange of ideas and experiences among workers in the field of mental health.
3. To cooperate with other sections of the association in utilizing their skills in the solution of mental health problems, and integrating mental health with other areas of public health.
4. To focus public health skills on the epidemiology of mental disease, the promotion of mental health, the organization of preventive services, and the organization of therapeutic and rehabilitative services.
5. To stimulate scientific studies, experiments and demonstrations in these areas.

Footprints on Birth Certificates

Legislation designed principally to prevent (1) mix-up of newborn infants in hospitals and (2) attempts to circumvent adoption laws by fraudulent birth registrations now requires that footprints of the infant and fingerprints of the mother be imprinted on the reverse side of the birth certificate. Local health officers, who serve as local registrars, are not permitted to accept a birth certificate without these imprints.

Advisory Hospital Council Considers 1956-57 State Plan

(Continued from page 118)

between county and private hospital beds is undesirable.

The diagnostic and treatment center state plan for 1955-56 contains an inventory of outpatient departments of hospitals and established the policies that applications will be considered for allocation of diagnostic and treatment center funds in the priority sequence established for general hospital beds. This policy was considered an expedience when adopted for the last fiscal year because lack of information indicated there would be difficulty in establishing relative need for facilities to serve outpatients in the various parts of the State. This lack of adequate information appears still to exist. As an alternative to the 1955-56 plan, priority sequence for diagnostic and treatment centers will be based upon the relative need for and merit of individual projects. Factors to be considered in this evaluation will include: hospital affiliation, organization of outpatient department, integration of staffing with hospital inpatient services, demonstration of professional support, adequacy of demonstrated community resources and interest and training and research activities to be conducted in the clinic.

Also approved was a recommendation that the department work with groups interested in rehabilitation to establish an approved basis for inventorying rehabilitation facilities throughout the State and establishing improved criteria for evaluating applicants for funds.

In the 1956-57 plan, priority needs for nursing homes will be based on the 111 general hospital service areas. In 1955-56 the planning was on a regional basis.

No significant policy changes were considered necessary in the categories of tuberculosis, mental and chronic facilities and public health centers.

Only about 8 percent of the estimated 320,000 blind persons in the United States are employed although experience has indicated that about 25 percent of those disabled by blindness can be trained for gainful employment.—*Public Health Reports*, vol. 70, No. 12.

Program Goals for Cerebral Palsied Children

(Continued from page 117)

We have services for cerebral palsied children in California which center around a treatment and educational program and which must be based upon sound community services, both official and voluntary. We are

proud of the program's progress after 10 years' experience but are acutely aware of its shortcomings. We look to the future hopefully and with deep faith that it will bring improved training, and research leading to new and more effective methods of treatment, education, and ultimately prevention.

Review of Reported Communicable Diseases Morbidity by Month of Report December, 1955

Diseases With Incidence Exceeding the Five-year Median

Diseases	Dec. 1955	Dec. 1954	Dec. 1953	Five-year median
Amebiasis	86	48	42	48
*Coccidioidomycosis	28	5	4	5
Diphtheria	17	9	6	6
Food poisoning	95	143	9	52
Hepatitis, infectious, including serum hepatitis	155	268	180	108
Measles	1,375	1,476	1,620	1,085
Mumps	3,208	2,562	2,674	2,562
Rabies, animal	31	8	25	10
Shigellosis	253	127	105	105

Diseases Below the Five-year Median

Diseases	Dec. 1955	Dec. 1954	Dec. 1953	Five-year median
Brucellosis	2	6	3	6
Encephalitis (type undetermined)	5	11	15	12
Malaria	2	4	8	4
Meningitis	26	28	40	28
Pertussis	124	584	177	269
Polioyelitis (total)	130	166	323	226
Polioyelitis (paralytic)	87	103	214	161
Salmonella	67	231	104	104
Strep. infections, including scarlet fever	483	757	813	749
Tetanus	2	5	5	5
Typhoid fever	5	6	11	8

Venereal Diseases

Diseases	Dec. 1955	Dec. 1954	Dec. 1953	Five-year median
Syphilis	478	574	520	555
Gonococcal infections	1,069	1,423	1,429	1,373
Chancroid	5	8	13	—
Granuloma inguinale	—	—	1	—
Lymphogranuloma venereum	2	3	8	—

* Prior to July 1, only disseminated form was reportable.

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Monterey CCS Program

In the December 15th *California Health*, page 94, in the article "Independent CCS Program Starts in Monterey County," Monterey County was inadvertently omitted from a listing of 18 California counties which carry on independently operated crippled children service programs. Monterey County has conducted an independent program since January, 1950, under the administration of the Monterey County Health Department.

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